

Europe's men need their own health strategy

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ANALYSIS

Europe's men need their own health strategy

A recent European report on men's health shows that it lags behind that of women. **Alan White and colleagues** analyse the problems and call for more policy, practice, and research aimed specifically at men

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Ten years ago the *BMJ* published a special issue on men's health.¹ It noted how, although men fare better than women in most conventional measures such as top jobs and earnings, this advantage is not reflected in their health. A report we produced this summer, *The State of Men's Health in Europe*,^{2,3} shows that little has changed. At any given age, men are still more likely than women to die from most of the leading causes, and in the European Union men have more than twice as many deaths a year as women throughout the working ages (15-64 years). This high level of premature mortality in men has psychological, social, and economic consequences for relatives, households, communities, and the workplace. Yet, in both national and European health policy, men and "masculinity" are largely taken for granted. This has limited the development of evidence based programmes that meet their health needs.

Differences in mortality and morbidity are not simply the result of biological factors; nor are they intractable. In fact, the health gap between men and women varies considerably. It is much greater in eastern Europe than in western Europe,⁴ and within countries it is influenced by class, education, employment, and other social determinants.⁵ The clustering of material, cultural, and psychosocial factors seems to be particularly detrimental to the health of many men.⁶ These factors contribute to gendered lifestyles and behaviours that have traditionally been seen as predominantly "masculine"⁷ and that cause many of the premature deaths in men. Traditional masculine attitudes are associated with unhealthy behaviours such as poor diet,⁸ smoking, excessive alcohol consumption,⁹ non-use or delayed uptake of health services,¹⁰ and higher likelihood of injury. All of these factors are more common among men living in eastern

Europe than those in western Europe and in poorer material and social conditions everywhere.¹¹ Men also seem to have adapted less well than women to the changes that have accompanied the political and social upheavals in eastern Europe in recent decades, such as more transient and unstable working conditions, increasing unemployment, and changing family structures (reduction in marriage and increased divorce).¹²

Yet, paradoxically, men often view themselves as having better health than women. There is some justification for this view: those men who survive into old age report less disability than women of the same age²; but what is overlooked is that fewer live this long.¹³ Though the average difference in life expectancy between men and women in the European Union is 6.1 years, it ranges from 11.3 years in Latvia to 3.3 years in Iceland and Lichtenstein.² Thus, men in general, and younger men in particular, tend to minimise the potential consequences of practices damaging to health and to see themselves as invulnerable to danger and risk.

The situation is at last beginning to change. *The State of Men's Health in Europe* provides a springboard for a range of policy measures, innovations in practice, and research into men's health.² The report, together with emerging men's health policy and initiatives in EU member states and the work of key non-governmental organisations (including the European Men's Health Forum, the Men's Health Forum, and the Nordic Men's Health Network) have begun to enhance our understanding of what can be done to improve men's health. Here we review the report's key conclusions.

Policy

Given the many influences on men's health, policy responses must take a broad perspective, acknowledging the variety of social positions, lifestyles, and health needs of men and women, rather than focusing only on differences between them. Many measures designed to improve opportunities for men in employment, education, and other sectors will also help women. However, men may benefit disproportionately when they are at greatest relative risk—as is the case for whole population initiatives in areas such as preventing road traffic injuries (where death rates are three times higher for men) and workplace health and safety (where men account for 95% of fatal incidents).

Because policies may impinge differently on women and men, it is important to consider the effects on each separately. To date, few EU member states (Ireland, UK, and Denmark being the exceptions) have identified men as a specific population group for the strategic planning of health.¹⁴⁻¹⁶ Ireland's approach to developing and implementing policy on men's health can be a particular source of inspiration for other countries (box 1).¹⁷

The large variations in trends in male mortality across Europe² highlight the potential benefits of a broader implementation of measures that have reduced male deaths. An obvious area is road traffic deaths, which have already fallen substantially in countries that have joined the EU since 2004, reflecting factors such as more effective enforcement of traffic laws and investment in safer roads. Although the percentage fall in deaths was similar in men and women between 2000 and 2009 (20.3% and 17.3%, respectively), the absolute reduction has been much greater for men (2640 fewer male deaths compared with 602 fewer female deaths).¹⁸

Similarly, the opening of markets in eastern Europe, and the accompanying improvements in diet and subsequently cardiovascular deaths have benefited men disproportionately.¹⁹ Nevertheless, cardiovascular disease still accounts for more deaths of men in eastern Europe than in western Europe (for example, 62% of male deaths in Bulgaria compared with 25% in France²). This points to the need for the broader implementation of established primary and secondary prevention measures that account for the sex/gendered nature of the disease—men develop the disease earlier than women and the risk factors are more prevalent in men.

Action is needed on several levels. The first is schools. Behaviours and values developed early in life have a critical influence on men's later health practices. There is a need for a visible, integrated focus on boys' and men's health within primary and secondary school curriculums that can foster positive models of physical, psychological, and social development.²⁰ This should challenge gender stereotypes that are harmful to men's health and develop boys' ability to maintain their emotional wellbeing, problem solving skills, and responsible decision making. This will lay the foundations for empowering men to manage their health more effectively, to make more informed decisions about their relative risk, and to use health services responsibly. An increased focus on schools must also tackle the problem of boys' lower educational performance.

The second level is the workplace. Employers and unions can work collaboratively to support policies and programmes to promote men's health in the workplace—not only through traditional occupational health measures but also by helping them to deal with lack of job security, prolonged sickness absence, and involuntary early retirement, all of which negatively affect men's health.²¹⁻²³ This requires governments and employers to consider the health of the workforce as an

investment and to recognise the increasingly strong evidence that work benefits physical and mental health and wellbeing. Unemployment not only impairs individuals' health but also leads to a loss of worth and self confidence, poorer social integration, and poverty. Work-life balance must also be considered. Measures that support and enable men to be more involved fathers (for example, paid paternal leave) benefit not only fathers but also their partners and children, and society as a whole.^{24 25} Although workplace interventions can help improve employees' health, men may be less likely than women to engage with them.²⁶

The third area for action is in policies that target marginalised subgroups of men, such as ethnic minorities, sexual minorities, disabled men, and those who are isolated in rural areas, homeless, or in prison, all of whom experience considerably higher morbidity and premature mortality.

Practice

Barriers to accessing health services still exist in many European countries, and these may exacerbate the traditionally lower use of appropriate care by men. It is thus important to identify and develop alternative services that engage men more effectively. However, these should not entrench or reinforce stereotypes that all men are unhealthy or uninterested in their health. An effective response must move beyond increasing access to family practitioners: it should extend to weight loss groups, counselling services, and health promotion activities. Paradoxically, although male socialisation patterns tend to result in men being less engaged with health and wellbeing issues than women, men are seldom the focus of targeted health education or health promotion.

Mental health is a case in point. Many men present their mental and emotional distress differently from women, so that the diagnosis is often missed. Men are less likely to contact health services because of mental health problems,²⁷ potentially placing them at risk of deterioration and suicide. Men commit suicide three to five times more often than women. Men may also feel compelled to use other coping strategies such as acting aggressively, being uncooperative with health professionals, rejecting offers of help, and resorting to alcohol misuse.

Although health initiatives aimed specifically at men have increased recently, much of this work has been small scale pilots with few assessed in definitive trials.²⁸ Nevertheless, longitudinal studies show that young men with more traditional beliefs about masculinity are significantly less likely to use health services²⁹ and that when they do seek help, flexible opening times, longer consultation times, the provision of lifestyle and behaviour modification programmes, and a comprehensive referral system are important to them.³⁰

Weaknesses in existing health services have stimulated interest in initiatives that bring health services to men in settings such as pubs, sports clubs, schools, and youth centres. The workplace is also an important setting in which to target services, screening initiatives, information, and support to men. One of the larger scale examples is the £1.6m (€1.85m; \$2.5m) invested in the English Premier League health initiative aimed at 18-35 year old male football supporters. As part of this three year programme, health trainers based in 16 clubs are engaging men to act on multiple aspects of physical, psychological, and social wellbeing. Clubs use a range of activities suited to their local male populations, including educational activities for supporters on match days and outreach work into schools and communities, weekly lifestyle classes, and football or multisport sessions for men. Baseline analysis shows that the initiative is reaching men

Box 1 Key steps in the development of Ireland's national men's health policy^{16 17}

- Men were identified as a specific population group
- A three year research project into men's health was commissioned to inform national policy
- A consultation process included national men's health days, targeted focus groups, and targeted and public calls for submissions
- Policy was based on an extensive review of national and international literature
- Meetings were held between government departments to finalise the policy and action plan

Underpinning principles

- To develop men's health, not just within a health policy context but in synergy with other government departments and across different sectors
- To adopt a social determinants and gender relations approach
- To include preventive and health promotion and community development to reach subgroups of men most in need.

Process for implementation

- National Implementation Group (including annual audit) has been established
- Independent evaluation will be undertaken after five years

Examples of actions resulting from policy

- Increased focus on men's health in the workplace and in community settings targeting disadvantaged men
- Development of guidelines for training in men's health
- Establishment of a national centre for men's health research
- Providing funding to the Men's Health Forum in Ireland to coordinate "Men's Health Week."
- The policy also called on national governing sporting bodies to provide a range of activities to stave off men's retirement from competitive sport. The Football Association of Ireland now runs a veterans football programme and the Gaelic Athletic Association has developed a social inclusion initiative for older men who are not participating in community life (www.gaa.ie/clubzone/gaa-social-initiative/description-of-initiative/)

in need.³¹ A clinical trial of the effectiveness of using football clubs as a conduit for improving men's fitness and weight is currently under way with the Scottish Premier League, under the banner of Football Fans in Training. The concept of "men's sheds," developed in Australia as a place for male focused activities outside the home and work,³² is now spreading into Europe, especially Ireland and the UK. Men's sheds may provide a captive audience for health promotion activities, and they may also be an important setting for challenging men's stereotypical beliefs about masculinity and healthcare.

Research

Research also presents a paradox. Although for many decades research on common diseases, and especially cardiovascular disease, was largely done on men and applied uncritically to women, this was mainly because of a combination of gender blindness and ease of sampling from workplaces rather than having men's specific needs as part of the research question. Until the mid-1990s, there was a dearth of research that had men as its main focus.

One limitation of much epidemiological and behavioural research is that the biological category "male" is conflated with the psychological and social concept "masculine." Yet how men construct beliefs, attitudes, and behaviours can have a crucial bearing on their health. More psychological and sociological research is needed into how different ideologies of masculinity influence healthy and unhealthy behaviour.⁷ For example, efforts to tackle binge drinking among young men will need to take account of the role that alcohol plays as a rite of passage to manhood for many young men and as a mechanism for defining collective gender practice.³³ Likewise, measures designed to stem the growing tide of male obesity will need to overcome men's scepticism and cynicism towards healthy eating messages and the strong connotations between dieting and femininity.⁸

More research into masculinity will enable a more nuanced analysis of differences in perspectives and experiences of health and illness, not just between men and women but between

different subpopulations of men.³⁴ Health practices of individual men must be interpreted within the broader economic and social contexts of their lives. We need to get to grips with the "intersections"³⁵ of gender with factors such as social class, educational attainment, employment status, race, and ethnicity in order to build evidence based and gender appropriate approaches to men's health.

Conclusion

Public debate on men's health tends to be dominated by negative portrayals of men and masculinity, where men are blamed for not attending health services and taking risks with their health. This is not helpful. We should use strategies that work with men in a constructive way.

A more focused approach to the physical and mental health of younger men needs to be balanced with one that also faces the health challenges of an ageing male population. The diversity of factors contributing to men's poorer health requires measures that not only recognise any gender equality issues but also highlight a more fundamental concern with equity. This relates to the right of all men—irrespective of social, cultural, political, or ethnic differences—to live long and fulfilling lives. In policy, practice, and research there is a pressing need to examine the "problems" with men's health and to tackle the underlying causes as well as the symptoms. This demands appropriate intersectoral and intergovernmental responses at both EU and national levels.

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Box 2. Examples of innovative initiatives that have benefited the health of men*Scottish well man health service pilots*³⁵

In 2003 the Scottish government funded 18 outreach projects aimed at improving men's health. It set out to reach men in deprived areas by setting up clinics in non-traditional healthcare settings:

- Fixed and mobile nurse led clinics
- Outreach work with homeless men
- Community based initiatives targeting disadvantaged men
- Pubs
- Workplace initiatives

Activities included awareness raising activities (health fairs and marketing events), brief health assessments, comprehensive health assessments with specially trained (usually nursing) staff, and community development endeavours such as the inclusion of a health dimension in adult education and training courses for unemployed men.

Evaluation showed variable success. Sessions held in community venues or workplaces were more likely to contact men who had not seen their general practitioner in the past two years. Over 3000 men received comprehensive health checks, 72% of whom were given healthcare advice and referred to another health service.³⁵

British Telecom (BT) Workfit

This workplace joint initiative between BT and the Communications Workers' Union comprised a 16 week internet based weight loss programme

- Over 16 000 participants were registered, 75% of whom were men
- About 5000 people could be tracked through the programme, with an average weight loss of 2.3 kg
- Over 65% of the participants reported sustained changes to their lifestyle as a direct result of the programme at 4 months
- A follow-up programme to increase cancer awareness is under way³⁶

Royal Mail health initiative

Men comprise 80% of the Royal Mail's workforce. The initiative included:

- Rapid access physiotherapy
- Locating clinics at main sorting offices
- Health screening
- Health promotion, including activities aimed at smoking and back pain

An initial investment of £46m produced estimated savings of over £227m by reducing worker absences from 7% to 5% between 2004 and 2007.³⁷

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